Advantage 65

Notification of Changes to Your Member Handbook
The Local Choice Health Benefits Program

This booklet consolidates notifications to the Advantage 65 health benefits plan from October 1, 2001 through July 1, 2004 and October 1, 2004 for some school groups. You may replace individual notification documents with this consolidated booklet. Keep this booklet with your Member Handbook, #T20078 (9/01) for a full and complete description of your coverage. You or your Benefits Administrator may view and print this Member Handbook from The Local Choice Web site at **www.thelocalchoice.virginia.gov** or from Anthem Blue Cross and Blue Shield's site at **www.anthem.com**.

1) **Your plan is administered by two plan administrators, as follows: Anthem Blue Cross and Blue Shield for medical benefits, and Medco Health Solutions, Inc. for prescription drug benefits.**
Effective July 1, 2004

2) **Your plan includes special provisions for prescription drug refills when traveling.**
Effective July 1, 2004

If you are planning to travel on vacation or leaving home for an extended period, you may need one or more early refills of your medication. Participating retail pharmacies and the Medco Health Home Delivery Pharmacy Service may provide one early refill (up to a 34-day or 90-day supply, as appropriate) to accommodate travel. However, for extended travel, multiple refill requests must be sent to:

The Department of Human Resource Management (DHRM)
Office of Health Benefits
Attn: State Health Benefits Program
101 North 14th Street, 13th Floor
Richmond, VA 23219
E-mail: **tlc@dhrm.virginia.gov**

Please include documentation of your dates of travel, the names of any prescriptions that you wish to request, and the number of refills that you will need. DHRM will evaluate your needs and approve all valid requests. If at all possible, please allow at least two to three weeks for processing your request. Also, please keep in mind that you will never be allowed to obtain more refills than you have been prescribed. That is, if your one-year prescription runs out in six months, you cannot get more than six one-month refills.

Page 20 - Outpatient Prescription Drugs

3) **The following is no longer excluded from your coverage: Services for diseases contracted or injuries sustained as a result of any act of war (declared or undeclared), voluntary participation in civil disobedience, or other such activities.** **Effective July 1, 2004**

Page 25 - Exclusions number 11)

4) The exclusion regarding medically necessary services and supplies is replaced as follows:
Effective July 1, 2004

Your coverage does not include benefits for services and supplies if they are deemed not medically necessary as determined by Anthem or ValueOptions at their sole discretion. Nothing in this exclusion shall prevent you from appealing Anthem or ValueOptions' decision that a service is not medically necessary.

However, if you receive inpatient or outpatient services that are denied as not medically necessary, or are denied for failure to obtain the required preauthorization, the following professional provider services that you received during your inpatient stay or as part of your outpatient services will not be denied under this exclusion in spite of the medical necessity denial of the overall services:
For inpatients

1. services that are rendered by professional providers who do not control whether you are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.
2. services rendered by your attending provider other than inpatient evaluation and management services provided to you. Inpatient evaluation and management services include routine visits by your attending provider for purposes such as reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your attending provider.

For outpatients - services of pathologists, radiologists and anesthesiologists rendering services in an (i) outpatient hospital setting, (ii) emergency room, or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician.

Page 37 - Exclusions, number 21)

5) <u>Appeals</u> under General Rules Governing Benefits is replaced as follows:
Effective July 1, 2004

Complaint and Appeal Process

You have access to both a complaint process and an appeal process. Should you have a problem or question about your health plan, the appropriate plan administrator's member services department will assist you. Most problems and questions can be handled in this manner. For medical benefits your plan administrator is Anthem. For behavioral health and EAP benefits your plan administrator is ValueOptions. Delta Dental is the plan administrator for routine dental and the optional expanded dental benefits. Medco Health is the plan administrator for your prescription drug benefits. You may also file a written complaint or appeal. Complaints typically involve issues such as dissatisfaction about your health plan's services, quality of care, the choice of and accessibility to your health plans' providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by your health plan. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

Complaint Process

Upon receipt, your complaint will be reviewed and investigated. You will receive a response within 30 calendar days of your health plan's receipt of your complaint. If we are unable to resolve your complaint in 30 calendar days, you will be notified on or before calendar day 30 that more time is required to resolve your complaint. We will then respond to you within an additional 30 calendar days.

Important: Written complaints or any questions concerning your medical, behavioral health, dental or prescription drug coverage may be filed to the following address:

Anthem Blue Cross and Blue Shield (for medical)
Attention: Member Services
P. O. Box 27401
Richmond, VA 23279

Medco Health Solutions, Inc. (for prescription drug)
Call 800-355-8279

Appeal Process

Your health plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider a coverage decision you find unacceptable. There are two types of appeals:

- Plan administrator appeals are requests to reconsider coverage decisions of pre-service or post-service claims. A separate expedited emergency appeals procedure is available to provide resolution within one business day of the receipt of a complaint or appeal concerning situations requiring immediate medical care. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain. All appeals to the plan administrator must be exhausted before an appeal can be made to the Department of Human Resource Management (DHRM).
- After plan administrator appeals are exhausted, you may request of DHRM an appeal process that includes an impartial clinical review by an independent, external reviewer of the final coverage decision made by the plan administrator. Additionally, other plan related issues may be appealed to DHRM as well. More information about this appeal may be found in the **Final DHRM Appeal** Process section.

How to appeal a coverage decision

To appeal a coverage decision, please send a written explanation to the appropriate plan administrator's address (see addresses in this section) of why you feel the coverage decision was incorrect. Alternatively, Anthem will accept a verbal request for appeal by calling a member services representative. You may provide any comments, documents or information that you feel the plan administrator should consider when reviewing your appeal. Please include with the explanation:

- The patient's name, address and telephone number;
- Your identification and group number (as shown on your identification card); and
- The name of the health care professional or facility that provided the service, including the date and description of the service provided and the charge.

Addresses:

Anthem Blue Cross and Blue Shield
Attn: Corporate Appeals Department
P.O. Box 27401
Richmond, VA 23279

Medco Health Solutions, Inc.
Attn: Coverage Appeals
8111 Royal Ridge Parkway
Irving, TX 75063

How the plan administrator will handle your appeal

In reviewing your appeal, the plan administrator will take into account all the information you submit, regardless of whether the information was considered at the time the initial coverage decision was made.

A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a practitioner who holds a non-restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as one who typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

The plan administrator will resolve and respond in writing to your appeal within the following time frames:

- For pre-service claims, the plan administrator will respond in writing within 30 days after receipt of the request to appeal;
- For post-service claims, the plan administrator will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals, the plan administrator will respond orally within one working day after receipt from the member or treating provider of the request to appeal, and will then provide written confirmation of its decision to the member and treating provider within 24 hours thereafter.

When the review of your appeal by the plan administrator has been completed, you will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the plan provision(s) on which the determination is based. You will also be entitled to receive, upon request and at no charge, the following:

- Reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- Any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- The explanation of the scientific or clinical judgment as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- The identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant's adverse decision, whether or not the advice was relied upon.

Final DHRM Appeal Process

To further appeal the final coverage decision made by your health plan through its internal appeal process, you must submit to the director of the Commonwealth of Virginia, Department of Human Resource Management, in writing within 60 days of your health plan's denial, the following:

- Your full name;
- Your identification number;
- The date of the service;
- The name of the provider for whose services payment was denied; and
- The reason you think the claim should be paid.

You are responsible for providing DHRM with all information necessary to review the denial of your claim. The Department will ask you to submit any additional information you wish to have considered in this review, and will give you the opportunity to explain, in person or by telephone, why you think the claim should be paid. Claims denied due to such things as policy or eligibility issues will be reviewed by the director of DHRM. Claims denied because the treatment provided was considered not medically necessary will be referred to an independent medical review organization.

For issues of medical necessity, the medical review organization will examine the final denial of claims or treatment authorizations to determine whether the decision is objective, clinically valid, and comparable with established principles of health care. The decision of the medical review organization will:

- be in writing;
- contain findings of fact as to the material issues in the case and the basis for those findings; and
- be final and binding if consistent with law and policy.

With other plan-related appeals to DHRM, if after review, the denial is upheld, that denial is final.

Beyond any final denial, you may appeal that determination as per the provisions of the Administrative Process Act within 30 days of the final DHRM determination.

You may download an external appeals form at **www.thelocalchoice.virginia.gov**.

Notice in Writing

A notice sent to you by a plan administrator (Anthem, ValueOptions, Delta Dental or Medco Health) is considered "given" when delivered to the Department of Human Resource Management or your benefits administrator. If the Commonwealth of Virginia, or any one of the plan administrators must contact you directly, a notice sent to you is considered "given" when mailed to the enrolled member at the address shown in the Commonwealth of Virginia's records. Be sure to notify the Department of Human Resource Management if your address changes.

Page 7 - General Rules Governing Benefits, number 8)

6) Continuation of Coverage under Basic Plan Provisions, is replaced as follows:

Effective July 1, 2004

Extended Coverage

Extended Coverage (for employers with 20 or more employees) is a continuation of Plan coverage when it would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. Extended Coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees or retiree group participants, and dependent children of employees or retiree group participants may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect Extended Coverage must pay the full cost of coverage plus an administrative fee.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan due to the occurrence of any of the following qualifying events:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee or retiree group participant, you will become a qualified beneficiary if you will lose your coverage under the Plan due to the occurrence of any of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan due to the occurrence of any of the following qualifying events:
- The parent/employee/retiree group participant dies;
- The parent's/employee's hours of employment are reduced;
- The parent's/employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced, causing the child(ren) to lose eligibility; or
- The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer Extended Coverage to qualified beneficiaries only after the benefits administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Commonwealth of Virginia will be responsible for providing qualified beneficiaries with their right to elect Extended Coverage.

For other qualifying events (divorce of the employee/retiree group participant and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you (or any individual representing the qualified beneficiaries) must notify your benefits administrator. The Plan requires you to notify the benefits administrator within 60 days of the date coverage would be lost due to the qualifying event. Your designated benefits administrator must be provided with written notification including the following information:

- The type of qualifying event (e.g., divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse or dependent child);
- The date of the qualifying event;
- Documentation to support the occurrence of the qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support);
- The written signature of the notifying party.

Once the benefits administrator receives timely notice that a qualifying event has occurred, Extended Coverage will be offered to the qualified beneficiaries. For each qualified beneficiary who makes a timely Extended Coverage election (as defined in the Election Notice), Extended Coverage will begin on the date that Plan coverage would have been lost due to the qualifying event. Failure to provide timely and complete notification of the qualifying event will result in loss of Extended Coverage eligibility.

Extended Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee or retiree group participant, your divorce, or a dependent child losing eligibility as a dependent child, Extended Coverage lasts for up to 36 months.

Coverage that is terminated in anticipation of a qualifying event (e.g., divorce) is disregarded when determining whether the event results in a loss of coverage. Upon receiving notice of the event, as defined above, the benefits administrator must make Extended Coverage available and effective on the date of the event, but not before.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, Extended Coverage lasts for up to 18 months. There are two ways in which this 18-month period of Extended Coverage can be extended.

Disability Extension of 18-Month Period of Extended Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of Extended Coverage and you notify your benefits administrator in a timely fashion (as defined below), you and your entire family can receive up to an additional 11 months of Extended Coverage, for a total maximum of 29 months. You (or any individual representing the qualified beneficiaries) must make sure that your benefits administrator is notified in writing of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of Extended Coverage. In addition, the following information must be provided in writing:

- the name of the affected qualified beneficiary (e.g., spouse or dependent child);
- the date of the determination;
- documentation from the Social Security Administration to support the determination;
- the written signature of the notifying party.

Failure to provide timely and complete notification of the disability determination will result in loss of eligibility for the extension.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving Extended Coverage, the spouse and dependent children in your family can get additional months of Extended Coverage up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies or

gets divorced. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you (or any individual representing the qualified beneficiaries) must make sure that your benefits administrator is notified of the second qualifying event within 60 days of the date coverage would be lost due to the second qualifying event. This notice must be delivered (by mail or hand delivery) to your benefits administrator in writing and include the following information:

- The type of second qualifying event (e.g., divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse or dependent child);
- The date of the second qualifying event;
- Documentation to support the occurrence of the second qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support);
- The written signature of the notifying party.

Failure to provide timely and complete notification of the second qualifying event will result in loss of Extended Coverage eligibility.

In addition, when an employee's qualifying event (e.g., termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare, the employee's covered spouse and dependent children (but not the employee) become entitled to Extended Coverage for a maximum period that ends 36 months after the Medicare entitlement.

If You Have Questions

If you have additional questions about Extended Coverage, you should contact your benefits administrator or the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Active or former employees (and their covered dependents) may contact the designated benefits administrator within their employing agency. Retiree group participants (and their covered dependents) should contact the Virginia Retirement System or, for Optional Retirement Plan or Local Retirees (and their covered dependents), their pre-retirement agency's benefits administrator. The EBSA can address provisions of COBRA that also apply to the Public Health Service Act. Addresses and phone numbers are available through EBSA's Web site at **www.dol.gov/ebsa**.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep your benefits administrator informed of any changes in your address or the addresses of family members. You should also keep a copy, for your records, of any notices you send to your benefits administrator.

Page 29 - Basic Plan Provisions, number 9)

7) Your plan covers the private room charge in a hospital if you need a private room because you have a highly contagious condition; you are at greater risk of contracting an infectious disease because of your medical condition; or if the hospital only has private rooms.

Benefit Clarification July 1, 2004

Page 11 - Hospital Services

8) Under Eligibility, the Dependents section regarding unmarried biological and adopted children, and disabled children, is changed as follows: Effective July 1, 2003

Unmarried biological and adopted children may be covered by the The Local Choice Health Benefits Program to the end of the year in which they turn age 23 if the child lives at home and can be claimed on the parent's federal income tax return. There are limited circumstances which would allow eligibility under the plan even if the child does not live at home. Examples include:

- The child lives with the other parent if the employee is divorced, and
- The child lives away from home while attending college or boarding school.

Disabled adult children may be covered if the qualifying disability was diagnosed prior to the loss of eligibility for coverage due to age and has been approved by the plan administrator. Enrollment must occur within 31 days of loss of coverage as dependent children due to age. A child who later recovers is no longer eligible and may not re-enroll.

Children who are age 19 or older may not be covered by The Local Choice Health Benefits Program if they are not eligible to be claimed on the employee's income tax return as a dependent (i.e., children who are self-supporting).

Page 42 - Eligibility, Dependents

9) Certain drugs may not be available through the mail service (home delivery) pharmacy due to distribution restrictions imposed by the drug manufacturer. However, these drugs are available through the network retail pharmacies at their appropriate retail copayment level.

Benefit Clarification July 1, 2003

Page 20 - Outpatient Prescription Drugs

10) Disclosure of Protected Health Information to the Employer **Effective April 14, 2003**

(1) Definitions. Whenever used in this Article, the following terms shall have the respective meanings set forth below.

(a) Plan means the "State and Local Health Benefits Programs."

(b) Employer means the local employer group

(c) Plan Administration Functions means administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.

(d) Health Information means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined by the Health Insurance Portability and Accountability Act of 1996, subsequently referred to as HIPAA, in 45 CFR § 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined by HIPAA in 45 CFR § 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(e) Individually Identifiable Health Information means Health Information, including demographic information, collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse that identifies the TLC individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.

(f) Summary Health Information means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed: (1) names; (2) geographic information more specific than state; (3) all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older); (4) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e mail addresses, VIN, or serial numbers; (5) facial photographs or biometric identifiers (e.g., finger prints); and (6) any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.

(g) Protected Health Information ("PHI") means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

(2) The Plan, and the agents acting on its behalf, may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

(3) The Plan, and the agents acting on its behalf, will disclose PHI to the Employer only in accordance with HIPAA in 45 CFR § 164.504(f) and the provisions of this Section.

(4) The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose PHI to the Employer and acknowledges receipt of written certification from the Employer that of their intent to abide by these provisions.

Additionally, the Employer agrees:

(a) not to use or further disclose PHI other than as permitted in Section (4) or as required by law;

(b) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;

(c) not to use or disclose PHI for employment related actions or in connection with any other benefit or employee benefit plan;

(d) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in Section (4);

(e) to make PHI available to individuals in accordance with HIPAA in 45 CFR §164.524;

(f) to make PHI available for individuals' amendment and incorporate any amendments in accordance with HIPAA in 45 CFR § 164.526;

(g) to make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA in 45 CFR § 164.528

(h) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan and its agents available to the Department of Health and Human Services upon request; and

(i) if feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible.

(j) to ensure that adequate separation between the Plan and the Employer, as required by HIPAA in 45 CFR § 164.504(f), is established and maintained.

(5) The Plan will disclose PHI only to the following employees or classes of employees:

- Director, Department of Human Resource Management
- Director of Finance, Department of Human Resource Management
- Employer's Executive Contact
- Employer's Benefits Administrator

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

(6) Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Section by individuals described in Section (5) shall be considered "failure to comply with established written policy" (a Group II offense) and must be addressed under the Commonwealth of Virginia's Policy 1.60, Standards of Conduct Policy. The appropriate level of disciplinary action will be determined on a case-by-case basis by the agency head or designee, with sanctions up to or including termination depending on the severity of the offense, consistent with Policy 1.60.

(7) A health insurance issuer, HMO or third party administrator providing services to the Plan is not permitted to disclose PHI to the Employer except as would be permitted by the Plan in this Article and only if a notice is maintained and provided as required by HIPAA in 45 CFR § 164.520.

11) Exclusions, number 16) is replaced as follows: **Effective October 1, 2002**

Your coverage does not include benefits for services or supplies if they are deemed not medically necessary as determined by Trigon at its sole discretion.

However, if you receive inpatient or outpatient services that are denied as not medically necessary, or are denied for failure to obtain the required pre-authorization or primary care physician referral, the following professional provider services that you receive during your inpatient stay or as part of your outpatient services will not be denied under this exclusion in spite of the Medical Necessity denial of the overall services:
For Inpatients - 1) Services that are rendered by professional providers who do not control whether you are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.
2) Services rendered by your Attending Provider other than inpatient evaluation and management services provided to you. Inpatient evaluation and management services include routine visits by your Attending Provider for purposes such as reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your Attending Provider.

For Outpatients - Services of pathologists, radiologists and anesthesiologists.

Page 25 - Exclusions

12) Outpatient Prescription Drug Copayments change due to new three-tier structure:
Effective July 1, 2002

Network Retail Pharmacies
- Up to a 34-day supply* Changes from $27 to Tier 1 - $15; Tier 2 -$20; Tier 3 - $35

*You may purchase up to a 90-day supply at a network retail pharmacy by paying multiple copayments. For example, you pay two copayments for a 60-day or three copayments for a 90-day supply.

Mail Service Pharmacy
- Up to a 90-day supply Changes from $32 to Tier 1 - $18; Tier 2 - $33; Tier 3 - $63

Page 3 - Comparison of Medicare and Advantage 65 Plan
Page 21 - Copayments

13) The following change is repealed effective July 1, 2003. An appeal to the director of the Department must entail a liability of at least $300 to qualify for review by an outside impartial health entity, as follows: **Effective July 1, 2002**

Reviews for treatment authorizations or medical claims that have been denied will be sent to an impartial health entity. The impartial health entity shall examine the final denial of claims or treatment authorizations to determine whether the decision is objective, clinically valid, and compatible with established principles of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if consistent with law and policy. Medical appeals, to be accepted into the review process must entail a liability of at least $300 to the appellant or covered family member.

Page 7 - Appeals

14) Outpatient Prescription Drug Program Special Limits, number 1) under the 34-day supply from a retail pharmacy, the following limits are removed: 120 units or 500 milliliters of the drug, and two 10-milliliter vials of insulin. **Effective July 1, 2002**

Page 20 - Special Limits

15) Outpatient Prescription Drug Program Special Limits, number 7) is replaced as follows: **Effective July 1, 2002**

7) Prior authorization is required for certain medications. You will be notified in writing when a prescription is denied for coverage. Your physician will be notified of both approval and denial decisions.

Page 20 - Special Limits

16) Outpatient Prescription Drug Program Special Limits, number 8) i. - limitation removed. **Effective July 1, 2002**

Page 20 - Special Limits

17) Under Out-of-Country Major Medical Services, number 7) Dental services is replaced as follows: **Effective July 1, 2002**

Dental services and dental appliances a provider furnishes are covered when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia. Medically necessary dental services, resulting from an accidental injury while covered under the plan, are eligible for reimbursement if a plan of treatment from the dentist or oral surgeon is submitted to Trigon within 60 days of the date of the injury and subsequently approved. Dental services are also covered when required to diagnose or treat an accidental injury to the teeth if the accident occurs while the insured is covered under the plan. These services and appliances are covered for adults if rendered within a two-year period after the accidental injury.

The above two-year restriction may be waived for children under age 18. Actual treatment may be delayed if tooth/bone maturity is in question and standard industry protocols are followed. However, a treatment plan must be filed within 6 months of the accident and treatment must be completed within two years of active treatment commencement and prior to age 20. For the waiver to be granted, continuous coverage under the plan is required.

Major Medical Services include the repair of dental appliances damaged as a result of accidental injury to your jaw, mouth, or face. Injury as a result of chewing or biting will not be considered an accidental injury.

Page 16 - Services Which Are Eligible for Reimbursement

18) The section in the Code of Virginia pertaining to the The Local Choice Health Benefits Program was re-codified. As a result, the section reference is now § 2.2-2818.

Effective October 1, 2001

Page 46 - Statutory Benefits

Your Member Handbook may be printed at any time from the following Web sites: **www.thelocalchoice.virginia.gov** or **www.anthem.com**.